THE STATE of ALASKA
GOVERNOR SEAN PARNELL

Department of Health and Social Services

ALASKA HEALTH CARE COMMISSION
Anchorage

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September 16, 2014

Dear Alaska Medicaid Reform Advisory Group Members,

Thank you for your commitment to improving health care for vulnerable Alaskans through your service on the Medicaid Reform Advisory Group. Your efforts to understand and address the complex challenges associated with the Medicaid program are greatly appreciated. I thought it might be helpful to share with you a little background on the Commission, provide a broader context for your Medicaid reform discussion, discuss a few key concepts the Commission has considered in developing its recommendations, and suggest potential Medicaid initiatives that would align with the current body of Health Care Commission policy recommendations.

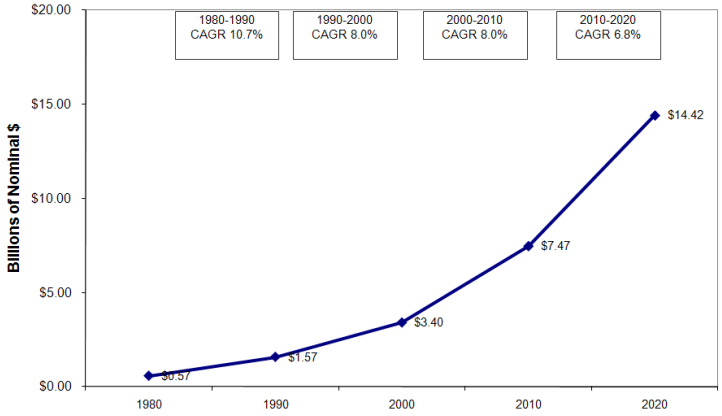
The Commission was established by the legislature in 2010 to advise the Governor and the legislature on policies for improving health and health care in our state. It is our vision that by 2025 Alaskans will be the healthiest people in the nation and have access to the highest quality, most affordable health care. While the Commission has a very broad charge and ultimate goal, our work over the past three years has been very focused on the central challenge of increasing value in Alaska's acute medical care delivery system so that costs are affordable and care is delivered as efficiently and effectively as possible. We haven't been addressing Medicaid specifically, but system-wide issues; and, we haven't been addressing other important components of the health care continuum – public health, behavioral health, and long term care.

We are charged with advising the Governor and legislature on state government policy change, and the emphasis has been on market-based solutions. Policy recommendations are intended to minimize state government intervention and management directly in the practice of medicine, and to provide appropriate government supports in the health care system that enable payers, providers and consumers to drive improved cost and quality of care in our state. At the same time recognizing that government at all levels is responsible for over 60% of all health care spending in Alaska, and one in every four dollars spent on health care here are administered by State government.

I. CONTEXT (partial)

Health care spending in Alaska doubled during the past decade and is on track to double again by 2020. We estimate that total dollars spent annually is now approximately $10 Billion. Alaska is second in the nation, behind Massachusetts, for per capita personal health care expenditures.

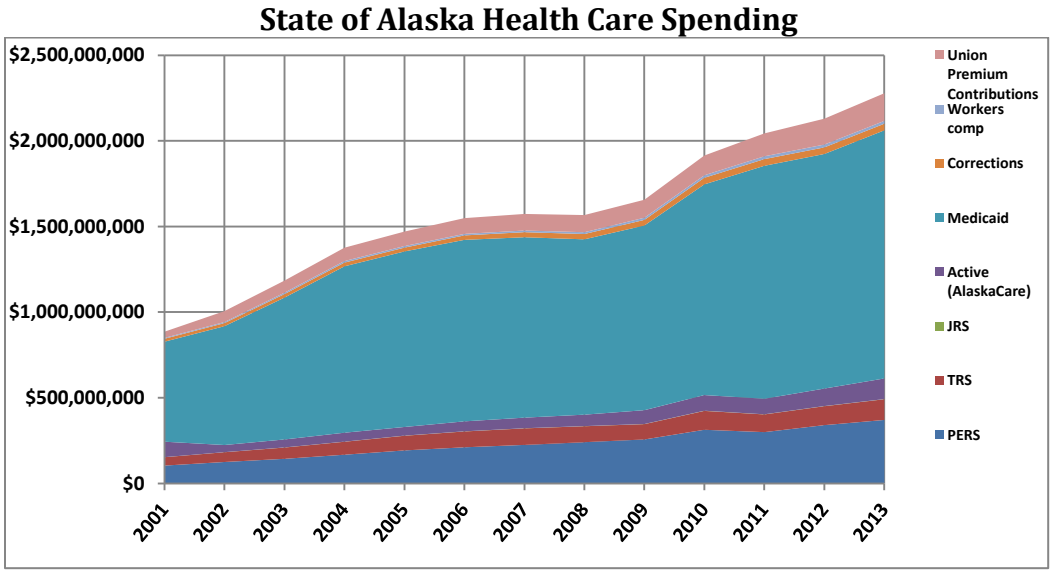
Total Health Care Spending in Alaska – History & Outlook



Institute for Social & Economic Research (ISER)/UAA with Mark A Foster & Associates, 2010

Rising costs have a real impact on the public sector, private employers and the economy. Employee health benefit costs in the U.S. more than doubled in the past decade, increasing 125% since 2003 compared to the rise in overall inflation of 29% and workers' earnings of 36% over the same period, creating difficult choices for employers and a burden on employees who share in the cost. Alaska's average annual per employee premiums for employer-based health insurance are the highest in the nation, at $17,902 for family coverage and $7,420 for individual coverage. A 2013 survey of Alaskan employers revealed that the proportion of those offering health benefits is declining due to cost concerns.

The Commission has heard testimony from Department of Defense officials and private sector employers that the high cost of employee health benefits in Alaska is a determining factor in business decisions regarding in which states to develop business opportunities and locate employees. A recent example shared by the Anchorage School District documented that teacher salaries have increased, on average and adjusted for inflation, 1% per year over the past 30 years in Anchorage, while employee health benefit costs have increased 15% per year over that same time period. The component of the cost to educate a child in Anchorage attributed to employee benefits has increased from approximately 20% to nearly 45% over that period. Reductions in teaching positions and other ASD staff are directly attributed to rising health care costs.



State spending for health care is approaching $2.5 Billion. The opportunity costs of the trade-offs between spending on health care versus other essential governmental services such child protection and public safety might not be as evident during increasing budget cycles. In the coming years as state revenue is projected to decline those trade-offs will become more obvious to the general public and the pressures to take a draconian approach to Medicaid cost containment will be too great to overcome. The question for State officials is – do we wait and take a blunt-axe approach to addressing the health care cost problem by slashing eligibility, benefits, and rates once the real budget crisis point hits, or can we reform the Medicaid program now in a way that improves cost, quality and outcomes, and also drives increased value in the broader health care delivery system?

This cost and spending context from an economic and State as payer perspective of course doesn't include other important contextual considerations from an access and health care delivery/provider perspective, but since those perspectives have been raised in most of the testimony presented to the Advisory Group to-date it is omitted here for the sake of brevity.

II. SOME KEY CONCEPTS

Health Care Costs = (Price x Utilization) + Administration

Health care prices in Alaska are the driver behind higher health care spending relative to other states and nations.

Medical prices in Alaska are among the highest in the nation. Medical price inflation here outpaced medical inflation nationally during the last decade, increasing 46% compared to 27% nationwide. A study conducted for the Commission in 2011 found that prices paid in our state through commercial insurance are 69% higher on average for physician services and 37% higher for hospital services compared to other states in our region. The price variance is particularly high for some specialties, where charges can be as much as four to five times higher for certain procedures here than in other states.

There are many reasons for higher prices here, including higher operating costs for providers (particularly rural), lack of economies of scale and other challenges associated with delivering care to a small population spread over a vast geography, a highly fragmented health care delivery system, and also high operating margins and greater pricing power among certain providers.

Solutions the Commission has recommended to address the problem of high prices generally across the health care industry include increased transparency, and consideration of state policies set in insurance rules that create market power imbalance and inhibit innovative payment strategies. The Commission hasn't addressed Medicaid specifically in this regard, but it is important to note that Medicaid fees here are very high. Alaska is one of only four states where Medicaid fees are higher than Medicare, and our fee schedule is high relative to other states in our region.

State Medicaid Fee Schedule Comparison – a few examples

Description/ Code	AK	ID	ND	OR	WA	WY
Office/outpatient visit (99214)	150.83	98.08	100.41	101.63	107.25	102.45
Obstetrical care (59400)	2821.81	1539.21	2339.40	2018.09	2034.50	n/a
Insert intracoronary stent 92980	1398.93	775.80	1189.17	676.03	523.52	n/a
Total knee arthroplasty (27447)	2410.07	1298.57	2009.69	1136.17	884.98	n/a
Total hip arthroplasty (27130)	2254.09	1210.03	1879.52	1062.45	827.40	n/a
Diagnostic colonoscopy 45378	579.70	338.69	512.69	304.18	227.86	n/a

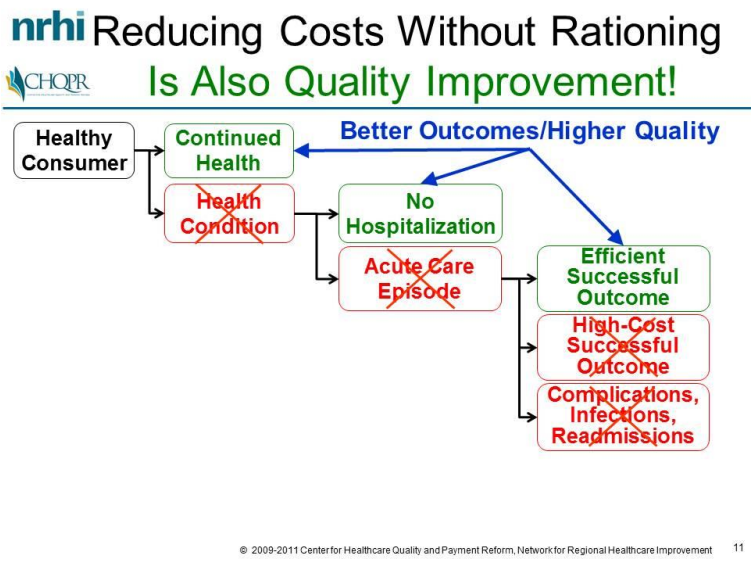
Milliman, Inc., November 2011
Report for the Alaska Health Care Commission

This is not to suggest that rates be slashed, but understood as a cost driver and considered in discussions regarding reform.

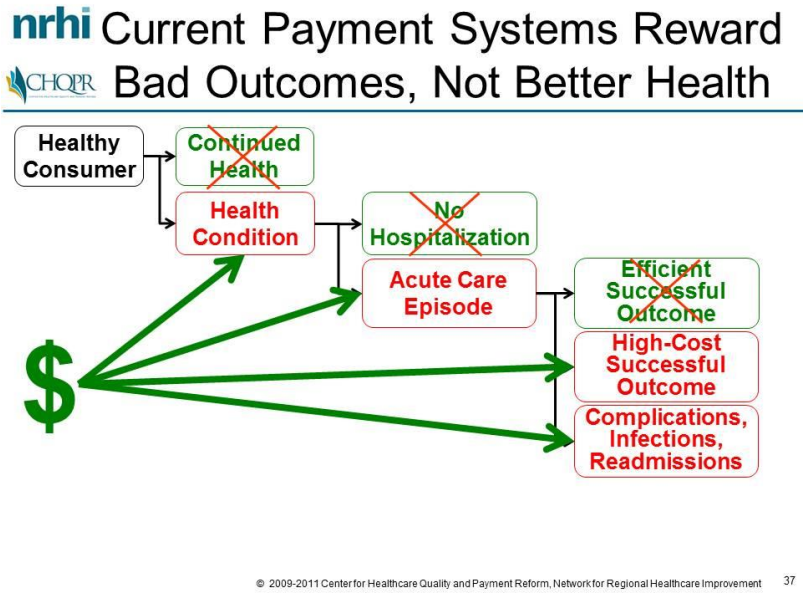
Health care utilization is not a factor in higher health care spending in Alaska relative to other states and nations; *however*, it is where the greatest opportunity for increasing value for health care purchasers, improving outcomes for patients, and increasing job satisfaction for clinicians lies.

The Institute of Medicine recently documented that 30% of all health care spending is waste. One driver of this problem is fee-for-service payment structures that reward delivery of high numbers of costly services, and disincentivize innovations that improve health and the efficiency and effectiveness of health care services. It compels health care delivery to be technology-driven, volume-driven, fragmented, and very expensive.

This is how a high-value health care delivery system works:

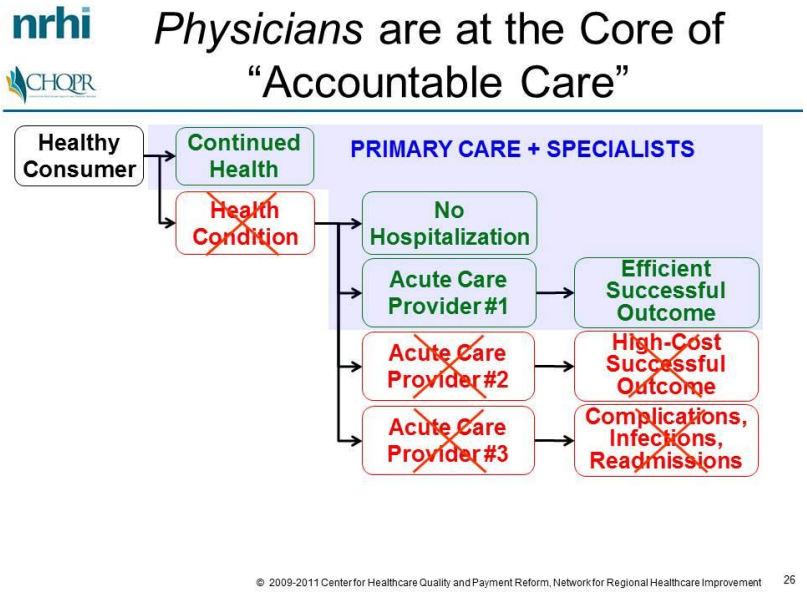


This is how our health care delivery system currently works:

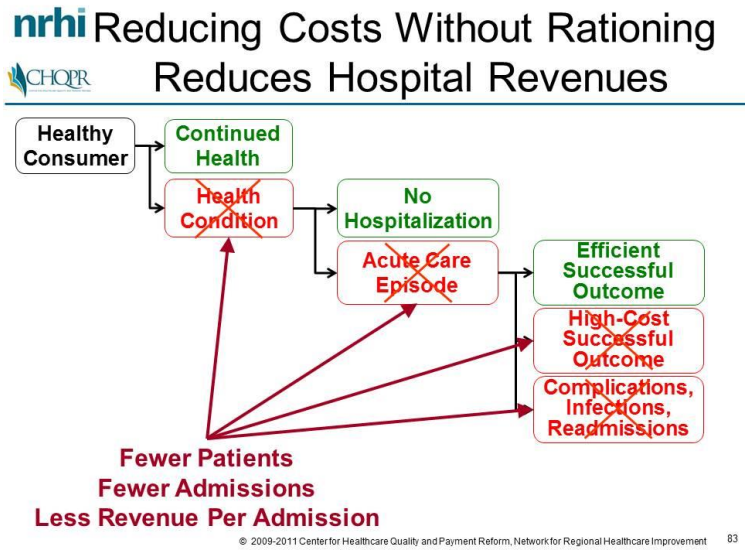


Solutions:

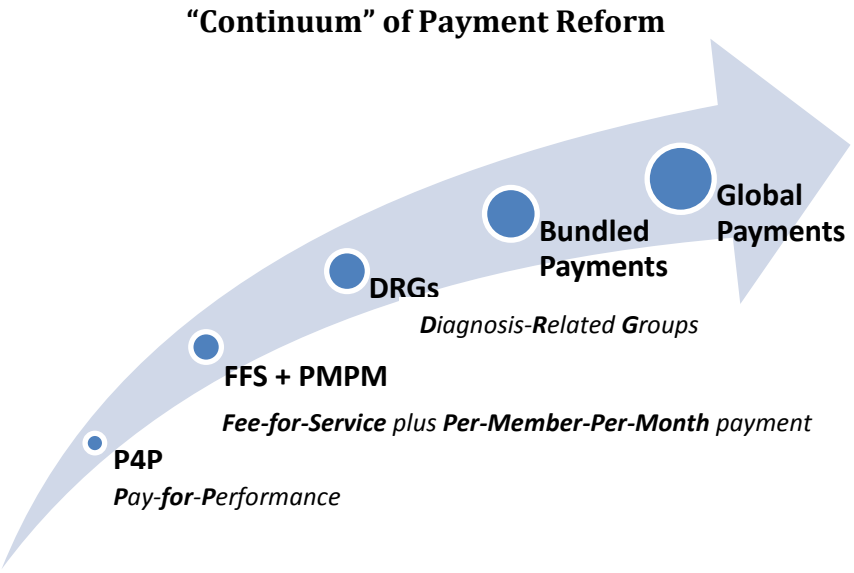
- ***Start with healthy communities and a strong public health system that protects and promotes the health of the population in a way that fosters individual responsibility for health and wellness;***
- ***Apply Evidence-Based Medicine principles to benefit design and clinical decisions to ensure the most effective care is provided; and,***
- ***Foster care coordination, complex case management, and clinical quality improvement — physician leadership is essential:***



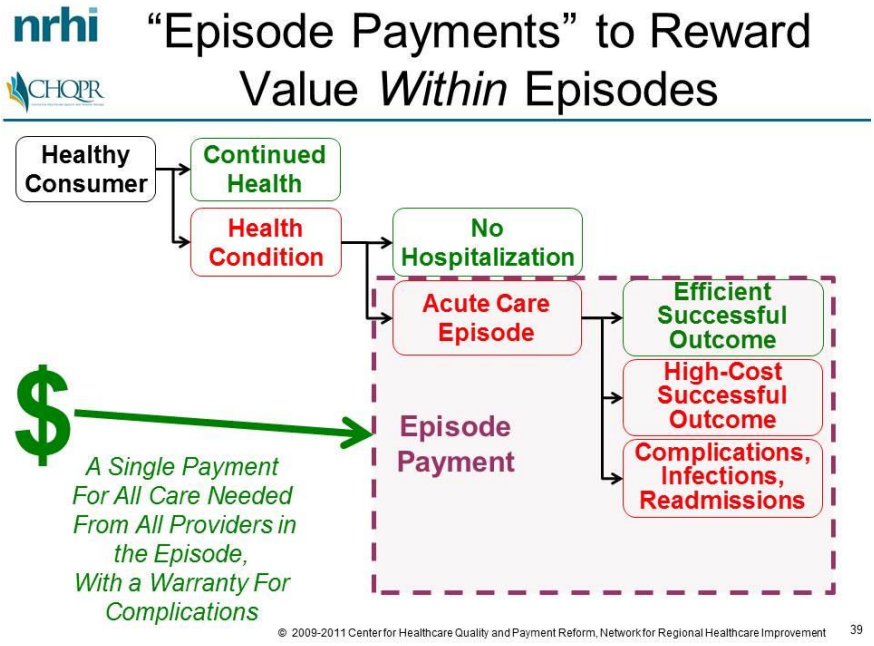
One problem with incentivizing the system to be high-value:



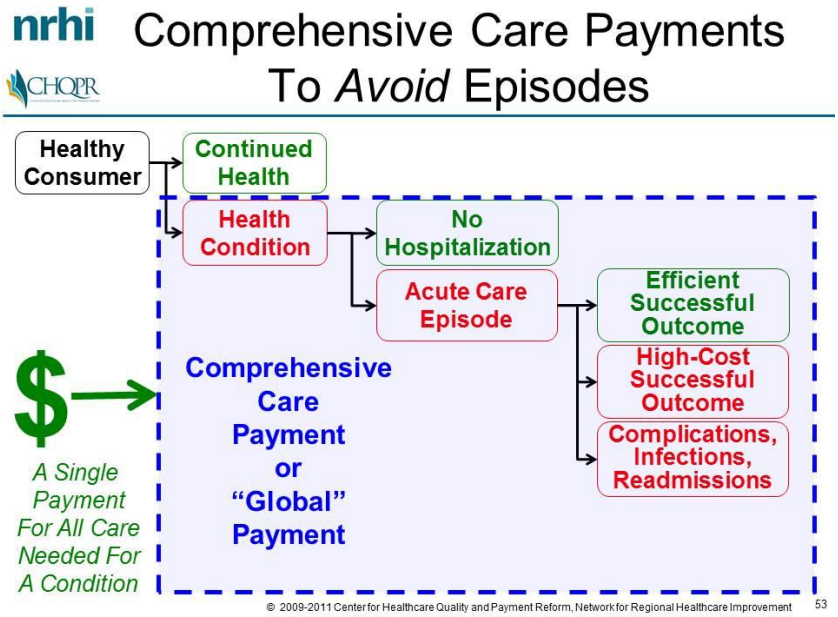
The solution must include restructuring payment mechanisms to incentivize value.



What are bundled payments?



What are global payments?



The Commission found that successful payment reform initiatives require:

- Capability to **manage financial risk** (payers and providers)
  - Data and analytics for monitoring utilization and quality
  - Actuarial expertise for financial risk analyses

- Capability to **manage health** (patients, providers, payers)
  - Methods for targeting high-risk patients
  - Capability to track, coordinate and follow-up on patient care
  - Patient education and self-management support

- **Alignment of organizational structures** (providers)
  - Trust relationships between physicians and hospitals
  - Significant regulatory barriers exist
  - Neutral, trusted facilitator may be required

- **Alignment of payment policies** (payers)
  - Multi-payer approaches to avoid further fragmentation of payment systems

III. ALASKA HEALTH CARE COMMISSION RECOMMENDATIONS

The Commission has identified a set of eight "Core Strategies" for State government to improve value in health care:

I. Ensure the best available evidence is used for making decisions

II. Increase price and quality transparency

III. Pay for value

IV. Engage and support employers to improve health plans and employee wellness

V. Enhance quality and efficiency of care on the front end

VI. Increase dignity and quality of care for seriously ill patients

VII. Focus on prevention

VIII. Build the foundation of a sustainable health care system

Numerous policy recommendations are associated with each of strategies. A summary of the Commission's Core Strategies and the complete body of policy recommendations is attached. Also attached is a list of potential Medicaid initiatives that would align with Commission recommendations.

I hope you find this information helpful. I wish you the best in your efforts to develop recommendations meeting the Governor's charge for improving Alaska's Medicaid Program. Please feel free to contact me with any questions you may have about this letter and about findings and recommendations of the Health Care Commission.

Sincerely,

Deborah Erickson
Executive Director
Alaska Health Care Commission

Attachments:

- Medicaid Initiatives that would Align with Alaska Health Care Commission Recommendations
- Core Strategies & Policy Recommendations, Alaska Health Care Commission

Medicaid Initiatives that would Align with Alaska Health Care Commission Recommendations

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I. Ensure the best available evidence is used for making decisions

a. Increase participation in Medicaid Evidence Based Decisions Project (MED)
b. Develop medical management capacity and tighten relationship with Qualis
c. Participate in creating and sustaining a SOA interagency EBM Collaborative
d. Sponsor Evidence-Based Medicine (EBM) Provider Forums
e. Strengthen and improve Prior Authorization processes, and establish user-friendly and efficient PA process for providers
f. Strengthen Preferred Drug List and Specialty Pharmacy Medical Management

II. Increase price and quality transparency

a. Participate in (i.e., submit claims data to) statewide All-Payer Claims Database (APCD) *(pending creation by legislature)*
b. Produce Annual Medicaid Report for the public
c. Produce reports on provider performance for the public

III. Pay for value

a. Develop health care analytic capabilities
b. Participate in APCD *(pending creation by legislature)*
c. Participate in creating and sustaining a SOA interagency health care purchasing collaborative; foster private payer participation.
d. Explore Payment Reform opportunities for phased approach to bundled payments and potentially managed care. At the same time, start with a phased approach to payment reform by implementing:
    i. Payment for Care Coordination services (start with "Super-Utilizers" Initiative); aligned with,
    ii. Patient-Centric Primary Care Medical Home or Case Management Pilot
e. Evaluate use of Centers of Excellence for certain high cost procedures
f. Strengthen fraud and abuse prevention and control

IV. Engage and support employers to improve health plans and employee wellness

V. Enhance quality and efficiency of care on the front end.

a. Implement Care Coordination ("Super-Utilizers") Initiative
b. Strengthen Existing Care Management and Case Management Programs
c. Implement Patient-Centric Primary Care Medical Home or Case Management Pilot

VI. Increase dignity and quality of care for seriously ill patients

VII. Focus on prevention

a. Control opioid use and abuse among Medicaid beneficiaries

VIII. Build the foundation of a sustainable health care system

a. Develop health care analytic capabilities
b. Participate in APCD *(pending creation by legislature)*